

## Exhibit 45

Jill S. Herbold

Bloomfield, CT

January 14, 2005

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UNITED STATES DISTRICT COURT

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DISTRICT OF MASSACHUSETTS

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No. 01CV12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY

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AVERAGE WHOLESALE PRICE LITIGATION

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DEPOSITION OF JILL S. HERBOLD, taken pursuant to

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the Federal Rules of Civil Procedure, at CIGNA

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Headquarters, 900 Cottage Grove Road, South Building,

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Bloomfield, CT, before Diana M. Noel, a Registered

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Professional Reporter, Certified Realtime Reporter,

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and Licensed Shorthand Reporter No. 199, in and for

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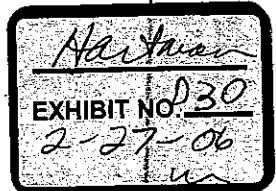
the State of Connecticut, on Friday, January 14,

20

2005, commencing at 12:48 PM.

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2 (Pages 2 to 5)

<p>1 APPEARANCES:</p> <p>2 FOR THE PLAINTIFFS:</p> <p>3 EDWARD NOTARGIACOMO, ESQUIRE (By Telephone)</p> <p>4 HAGENN BERMAN</p> <p>5 One Main Street</p> <p>6 Fourth Floor</p> <p>7 Cambridge, MA 02141</p> <p>8 Tel: (617) 482-3700</p> <p>9 FOR THE DEFENDANTS:</p> <p>10 ESTELLA J. SCHOEN, ESQUIRE</p> <p>11 PATTERSON, BELKNAP, WEBB &amp; TYLER, LLP</p> <p>12 1133 Avenue of the Americas</p> <p>13 New York, NY 10036-6710</p> <p>14 Tel: (212) 336-2000</p> <p>15 e-mail: eschoen@pbwt.com</p> <p>16 FOR CONNECTICUT GENERAL LIFE INSURANCE COMPANY</p> <p>17 AND THE DEPONENT, JILL S. HERBOLD:</p> <p>18 PETER D. ST. PHILLIP, JR., ESQUIRE</p> <p>19 LOWEY DANNENBERG BEMPORAD &amp; SELINGER, P.C.</p> <p>20 The Gateway</p> <p>21 One North Lexington Avenue</p> <p>22 White Plains, NY 10601</p> <p>Tel: (914) 997-0500</p> <p>e-mail: pstphillip@ldbs.com</p> <p>and</p> <p>MICHAEL WADE, ESQUIRE</p> <p>Counsel - Legal &amp; Public Affairs</p> <p>CIGNA</p> <p>900 Cottage Grove Road, S201</p> <p>Hartford, CT 06152-5026</p> <p>Tel: (860) 226-2457</p> <p>e-mail: michael.wade@cigna.com</p>	<p>1 JILL S. HERBOLD</p> <p>2 having been first duly sworn, was examined and</p> <p>3 testified as follows:</p> <p>4</p> <p>5 DIRECT EXAMINATION</p> <p>6 BY MS. SCHOEN:</p> <p>7 Q. Can you please state your name for the</p> <p>8 record.</p> <p>9 A. Jill Herbold.</p> <p>10 Q. Can you spell your last name.</p> <p>11 A. It's HERBOLD.</p> <p>12 Q. Ms. Herbold, my name Estella Schoen. I</p> <p>13 introduced myself briefly before the deposition</p> <p>14 started. I'm with the firm of Patterson, Belknap, Webb</p> <p>15 &amp; Tyler, and we represent the Defendants in this</p> <p>16 matter, and I'll be asking you asking you some</p> <p>17 questions today.</p> <p>18 Can you tell me if you've ever been</p> <p>19 deposed before?</p> <p>20 A. I have not.</p> <p>21 Q. To start out, we'll just go over a few ground</p> <p>22 rules for the deposition which you may have gone over</p>
<p>1 INDEX OF EXAMINATION</p> <p>2</p> <p>3 DIRECT EXAMINATION BY MS. SCHOEN:..... 4</p> <p>4 REDIRECT EXAMINATION BY MS. SCHOEN:..... 90</p> <p>5 CROSS EXAMINATION BY MR. NOTARGIACOMO:..... 80</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p>	<p>1 with your counsel.</p> <p>2 If you have any question or don't</p> <p>3 understand a question that I have for you, please just</p> <p>4 let me know, and I'll try to rephrase the question or</p> <p>5 explain it to you.</p> <p>6 Also, if I ask you a question, and --</p> <p>7 it's best to respond verbally so the court reporter can</p> <p>8 take it down as it's difficult for her to take down a</p> <p>9 nod of the head or a shake of the head.</p> <p>10 A. Yes.</p> <p>11 Q. And if you'd like to take a break, please</p> <p>12 just let me know, and we can take one.</p> <p>13 Do you understand, Ms. Herbold, that you</p> <p>14 are here today speaking on behalf of Cigna?</p> <p>15 A. Yes.</p> <p>16 Q. And can you tell me what you've done to</p> <p>17 prepare for giving testimony today?</p> <p>18 MR. ST. PHILLIP: Without going into any</p> <p>19 conversations we had, you can tell her what</p> <p>20 you've done.</p> <p>21 A. I have just been doing my job, and I have</p> <p>22 also met with our legal counsel.</p>

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<p>1 Q. Besides speaking with your legal counsel, did 2 you speak with anyone else at Cigna in preparation for 3 your testimony today? 4 A. Yes, I did. I spoke with one person that has 5 knowledge of the topics prior to me becoming involved 6 in these topics. 7 Q. Can you tell me what your current position is 8 at Cigna? 9 A. I'm responsible for strategy and policy as 10 well as financial analysis for practitioner 11 reimbursement. 12 Q. And is that -- do you have a formal title? 13 A. Yes. Assistant Vice President Practitioner 14 Reimbursement. 15 Q. How long have you held the position of 16 Assistant Vice President for Practitioner 17 Reimbursement? 18 A. Since February 2004. 19 Q. And how long have you been employed by Cigna? 20 A. Since August 1993. 21 Q. Just to get a little background, can you tell 22 me about your educational history after high school.</p>	<p>6 1 Q. So in approximately 1998, you shifted into a 2 different position? 3 A. Yes. I believe it was called Assistant 4 Actuary. 5 Q. And how long were you the assistant or an 6 assistant actuary? 7 A. Until 2001. 8 Q. And in 2001, did you -- were you given a new 9 title? 10 A. Yes. Assistant Vice President in Actuary. 11 Q. And for how long did you hold the position of 12 Assistant Vice President in Actuary? 13 A. I still do. 14 Q. And so are you -- do you have two titles? 15 One is Assistant Vice President of Actuary and one is 16 Assistant Vice President Practitioner Reimbursement, 17 or -- 18 A. To clarify, technically my title is Assistant 19 Vice President in Actuary right now. However, what I 20 oversee is practitioner reimbursement, so actuary is my 21 credentials. 22 Q. So your title is Assistant Vice President in</p>
<p>7 1 A. Yes. I have a Bachelor's degree in actuary 2 sciences from the University of Illinois. 3 Q. And can you tell me generally about your work 4 history after college but prior to coming to Cigna? 5 A. I came to Cigna directly from college. 6 Q. And can you tell me in 1993, when you first 7 came to Cigna, what was your position? 8 A. I was an actuarial student. 9 Q. For how long were you an actuarial student? 10 A. Three years. 11 Q. And so in approximately 1996, you shifted 12 positions? 13 A. Yes. At that time I became a fellow of the 14 Society of Actuaries, and so I had completed -- I had 15 finished being a student at that point and just have 16 done actuarial positions since then. 17 Q. So in 1996, your title shifted to -- do you 18 know what your new title was? 19 A. Associate Actuary perhaps. 20 Q. Can you tell me approximately how long you 21 were an Associate Actuary? 22 A. Two years perhaps.</p>	<p>9 1 Actuary, but you have responsibility for Practitioner 2 Reimbursement? 3 A. That's correct. 4 Q. Can you tell me what other -- can you 5 describe your responsibilities as they currently exist 6 as Assistant Vice President in Actuary? 7 A. Yes. My current responsibilities are for 8 practitioner reimbursement, strategy and policy, for 9 the financial analysis associated with practitioner 10 reimbursement, as well as the operational loading of 11 our contracts with practitioners. 12 Q. Are you involved in negotiations with 13 practitioners? 14 A. Not on a routine basis. 15 Q. But occasionally you would be? 16 A. From time to time; yes. 17 Q. Since 2001, have those been your 18 responsibilities? 19 A. No. 20 Q. Can you tell me -- 21 A. Those have been my responsibilities since 22 February of 2004.</p>

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<p>1 Q. Can you tell me what your responsibilities 2 were from 2001 through 20 -- through February of 2004? 3 A. Yes. I had a few different responsibilities 4 during that time period. They were all financial in 5 nature. One of those responsibilities was related to 6 the analysis of contracts with hospitals. Another one 7 related to the analysis of our national contracts with 8 national vendors. 9 Q. National vendors of what? 10 A. Of ancillary services such as laboratory 11 services and home healthcare, and another 12 responsibility was around the analysis of practitioner 13 reimbursement. 14 Q. When you did analysis of practitioner 15 reimbursement during that time period, can you tell me 16 what you were looking for? 17 A. The basic function, which I still oversee 18 today, is to analyze proposed changes in our contracts 19 with physicians to understand the financial impact to 20 the organization. 21 Q. And can you tell me at what point in the 22 negotiations with physicians do you -- does your</p>	<p>12 1 Q. Just going backwards in time, from 1996 to 2 1998, when you were an associate actuary, can you tell 3 me a little bit about your responsibilities in that 4 role? 5 A. Uh-hum. I was the pricing actuary for our 6 Medicare risk line of business that we had at the time. 7 And I also spent a year in corporate finance. 8 Q. Did any of your roles and responsibilities 9 from 1996 to 1998 involve looking at or involve in any 10 way reimbursement to physicians? 11 A. No. 12 Q. Did it involve in any way reimbursement to 13 hospitals? 14 A. No. 15 Q. Can you tell me briefly about your roles and 16 responsibilities from 1993 through approximately 1996, 17 when you were an actuarial student? 18 A. Yes. I worked in the defined contribution 19 pricing area in the retirement and investment business. 20 I also worked in -- it was doing financial projections 21 for two different lines of business in the healthcare 22 area, and those projections were gross revenues as well</p>
<p>11 1 analysis play a role? For example, does it play a role 2 at the starting point, at the mid point, at the 3 deciding on a final contract, or something else? 4 A. It can play an impact at any one of those 5 points. 6 Q. From 1998 through 2001, when you were an 7 Assistant Actuary, can you tell me a little bit about 8 your responsibilities then? 9 A. I was responsible for pricing of our PPO line 10 of business. 11 Q. Pricing to your clients like employers? 12 A. Setting trends and manual rates. 13 Q. To your employers -- I'm sorry, to your 14 clients? 15 A. Setting -- the manual rates are used to set 16 the rates with clients, but there's also an 17 underwriting process that's taken into account, so an 18 underwriter would use my manual rates to determine the 19 final rate to the client. 20 Q. Did your roles and responsibilities from 1998 21 to 2001 involve looking at reimbursement to physicians? 22 A. No.</p>	<p>13 1 as net underwriting gain. 2 Q. Did any of the work that are your 3 responsibilities from 1993 through 1996 involve looking 4 at reimbursements to physicians? 5 A. No. 6 Q. Did it involve looking at reimbursements to 7 hospitals? 8 A. No. 9 Q. So would I be correct to say that you had not 10 been involved in reimbursement or payments to 11 physicians for their services until 2001? 12 A. That's correct. 13 Q. And do you have an understanding of how 14 providers physicians have been reimbursed by Cigna for 15 pharmaceutical products that are administered in a 16 physician's office? 17 MR. ST. PHILLIP: Objection to form. 18 You can answer. I may object, and when 19 I do that, I'm just creating a place holder 20 in the record for an objection that may be 21 decided later by a court or by someone else. 22 So when I intervene and say objection, then</p>

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<p>14</p> <p>1 after that you can either answer – you can</p> <p>2 answer the question. The other thing I may</p> <p>3 do is instruct you not to answer, and then</p> <p>4 you can decide whether or not you're going to</p> <p>5 answer by instruction.</p> <p>6 A. Could you please repeat the question?</p> <p>7 Q. Sure.</p> <p>8 Do you have an understanding of how</p> <p>9 Cigna has reimbursed physicians for pharmaceutical</p> <p>10 products that are administered in a physician's office</p> <p>11 from the period of 1991 to the present?</p> <p>12 A. I have knowledge during part of that time</p> <p>13 period.</p> <p>14 Q. Can you tell me which part?</p> <p>15 A. Since 2001.</p> <p>16 Q. Since 2001, can you tell me how Cigna has</p> <p>17 reimbursed physicians for pharmaceutical products</p> <p>18 administered in their office?</p> <p>19 A. The reimbursement has been done per the</p> <p>20 contracting terms.</p> <p>21 Q. How are the contract terms established?</p> <p>22 A. Contract terms are frequently established via</p>	<p>16</p> <p>1 Q. And the rate exhibit, that would contain the</p> <p>2 reimbursement rate for services and – services of the</p> <p>3 physician?</p> <p>4 A. That is correct.</p> <p>5 Q. And it would also contain the rates for</p> <p>6 reimbursement of pharmaceutical products administered</p> <p>7 in the physician's office?</p> <p>8 A. That's correct.</p> <p>9 Q. And the rate exhibit would vary by</p> <p>10 physician's practice? In other words, there are many</p> <p>11 different rate exhibits for the different physician</p> <p>12 practices that Cigna contracts with?</p> <p>13 A. That is correct.</p> <p>14 Q. And is the variation in the rate exhibits due</p> <p>15 to the negotiation process that you described earlier</p> <p>16 with the physicians?</p> <p>17 A. That is correct.</p> <p>18 Q. For pharmaceuticals that Cigna would</p> <p>19 reimburse that have been administered in the</p> <p>20 physician's office, would the rate exhibit contain a</p> <p>21 line item for each particular pharmaceutical product,</p> <p>22 or would it group pharmaceutical products together in</p>
<p>15</p> <p>1 negotiations with the provider groups. They may also</p> <p>2 be established for physicians – well, using our</p> <p>3 standards for physicians that we actually don't have</p> <p>4 negotiations with.</p> <p>5 Q. So just to make sure I understand, you're</p> <p>6 saying in some cases you would go through a negotiation</p> <p>7 process with a physician or a physician group, but in</p> <p>8 other cases, the physician or physician group would</p> <p>9 accept a standard Cigna contract?</p> <p>10 A. That's correct.</p> <p>11 Q. And where in this contract – strike that.</p> <p>12 Would the contract contain the</p> <p>13 reimbursement that a physician would receive for a</p> <p>14 pharmaceutical product administered in the physician's</p> <p>15 office?</p> <p>16 A. Yes.</p> <p>17 Q. So that would be in the terms of the</p> <p>18 contract, or would it be in a fee schedule or a</p> <p>19 compensation schedule?</p> <p>20 A. The way it is typically done is there is a</p> <p>21 rate exhibit attached contract. I believe that it</p> <p>22 technically may become a part of the contract.</p>	<p>17</p> <p>1 some way?</p> <p>2 A. Generally it would group pharmaceutical</p> <p>3 products together.</p> <p>4 Q. And do you know if reimbursement for</p> <p>5 pharmaceutical products may, in some cases at least, be</p> <p>6 reimbursed based on some industry benchmark?</p> <p>7 MR. ST. PHILLIP: Objection.</p> <p>8 A. Yes. If that is what was negotiated.</p> <p>9 Q. So in some cases, the negotiations may yield</p> <p>10 a reimbursement rate that is based on a industry</p> <p>11 benchmark, but in other cases it would not?</p> <p>12 MR. ST. PHILLIP: Objection.</p> <p>13 A. Yes.</p> <p>14 Q. Do you know what industry benchmarks –</p> <p>15 benchmark or benchmarks may be used?</p> <p>16 A. Average wholesale price is the typical. I do</p> <p>17 not recall seeing any other contracts that use industry</p> <p>18 benchmarks – use anything but average wholesale price.</p> <p>19 Q. If the reimbursement rate for physicians for</p> <p>20 pharmaceuticals is not expressed as a – as in relation</p> <p>21 to the average wholesale price, how else would it be</p> <p>22 expressed in the contract?</p>

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<p>18</p> <p>1 A. Sometimes it is expressed that we -- the</p> <p>2 reimbursement will be per Cigna's national standard</p> <p>3 injectable reimbursement, and on occasion, it could be</p> <p>4 specified that the reimbursement is based on a percent</p> <p>5 of the billed charges.</p> <p>6 Q. Can you tell me approximately in what percent</p> <p>7 of cases would the reimbursement be based on the AWP</p> <p>8 benchmark that you just described?</p> <p>9 MR. ST. PHILLIP: What time period are</p> <p>10 we talking about?</p> <p>11 MS. SCHOEN: Well, we were talking about</p> <p>12 since 2001, because the witness testified</p> <p>13 that prior to that she was not sure of the</p> <p>14 methodology.</p> <p>15 A. Since the 2001 time period, we put a change</p> <p>16 into effect and established that national standard in</p> <p>17 January of 2002, and since that time, I believe</p> <p>18 approximately half of the reimbursement has been based</p> <p>19 like AWP standards versus approximately half according</p> <p>20 to our national standards.</p> <p>21 Q. And you mentioned another option which is a</p> <p>22 percentage of billed charges?</p>	<p>20</p> <p>1 Q. And how did that correspond with the</p> <p>2 pharmaceutical products?</p> <p>3 A. It is my understanding, without having</p> <p>4 pharmacy expertise, that -- pharmaceutical products are</p> <p>5 each assigned an NDC, National Drug Code, I believe,</p> <p>6 and there are multiple NDCs that may be billed under a</p> <p>7 HCPCS code.</p> <p>8 Q. Like a J-code?</p> <p>9 A. Yes. A J-code is a HCPCS code.</p> <p>10 Q. So for 13 J-codes since September 7, 2004,</p> <p>11 Cigna has been using the alternate methodology that you</p> <p>12 just described?</p> <p>13 A. That is correct.</p> <p>14 Q. Now, putting aside those 13 J-codes, Cigna</p> <p>15 has had its national standard injectable reimbursement</p> <p>16 rate since January of 2002, and would there be any</p> <p>17 other factors that Cigna would consider in setting the</p> <p>18 reimbursement rate for the remainder of the drugs?</p> <p>19 A. No.</p> <p>20 Q. So you described to me that Cigna would look</p> <p>21 at the code and sometimes would set it at the AWP,</p> <p>22 sometimes would set it at a percentage less than AWP --</p>
<p>19</p> <p>1 A. Very small.</p> <p>2 Q. Can you tell me how Cigna's national standard</p> <p>3 injectable reimbursement rate is set?</p> <p>4 A. It is a complex setting. This will take a</p> <p>5 few minutes.</p> <p>6 Q. You can tell me -- I guess to start, maybe to</p> <p>7 try to simplify it -- just the broad factors that go in</p> <p>8 or the sources Cigna uses if that helps at all.</p> <p>9 A. The -- for many of the HCPCS codes that are</p> <p>10 included within the scope of injectables, we start</p> <p>11 looking at the average wholesale price, and to some of</p> <p>12 those we will set the reimbursement at equal to the</p> <p>13 average wholesale price. Others, we will reimburse</p> <p>14 less than the average wholesale price.</p> <p>15 And there are other codes,</p> <p>16 approximately -- I believe it's 13 codes -- which,</p> <p>17 since September 7th of 2004, we have -- we changed the</p> <p>18 reimbursement methodology, and to set the fees on those</p> <p>19 codes, we are using physician acquisition costs as well</p> <p>20 as AWP.</p> <p>21 Q. And that's for 13 pharmaceutical products?</p> <p>22 A. 13 HCPCS codes.</p>	<p>21</p> <p>1 A. Yes. The percentages were fixed. They</p> <p>2 varied by code, but they are fixed. They don't change</p> <p>3 from time to time.</p> <p>4 Q. So for a particular code, Cigna would choose</p> <p>5 a percentage AWP and stick with that percentage?</p> <p>6 A. That's correct, unless we decided there is</p> <p>7 appropriate reason to change it.</p> <p>8 Q. Can you tell me the range below AWP that</p> <p>9 these rates and the Cigna national standard injectable</p> <p>10 reimbursement rate was varied?</p> <p>11 A. Typically 15 percent. We have codes that are</p> <p>12 up to 45 percent below AWP.</p> <p>13 Q. And you mentioned, I believe, that some</p> <p>14 J-codes may be set at average wholesale price?</p> <p>15 A. That is correct.</p> <p>16 Q. Can you tell me what accounts for this -- the</p> <p>17 variation in the reimbursement rate?</p> <p>18 MR. ST. PHILLIP: Objection.</p> <p>19 You can answer.</p> <p>20 A. The variation is based on what we can or what</p> <p>21 our subsidiary is willing and able to provide the</p> <p>22 service to our members for.</p>



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<p>1 Q. When you say the subsidiary, what do you 2 mean? 3 A. It's a Cigna subsidiary. 4 Q. Are you referring to the Cigna subsidiary 5 that would be providing the health plan services to the 6 members? 7 A. The Cigna subsidiary that provides 8 pharmaceutical services. 9 Q. Does that subsidiary have a name? 10 A. Tel-Drug. 11 Q. So why would -- strike that. 12 Why is Tel-Drug deciding what the 13 reimbursement rate should be as opposed to another part 14 of Cigna? 15 A. The physicians, rather than acquiring the 16 injectable themselves, they can instead get it from 17 Tel-Drug and still administer it in their office, and 18 Tel-Drug will bill Cigna directly for the service. So 19 the physician never has to worry about paying or 20 receiving reimbursement for the injectable. 21 Q. So what if a physician wanted to purchase the 22 drug himself and seek reimbursement from Cigna? Would</p>	<p>22 1 A. No. 2 Q. And Tel-Drug is a -- as you said, it's a 3 subsidiary of Cigna? 4 A. That's correct. 5 Q. So I just want to make sure I understand 6 since it seems a little complicated. 7 So if a physician receives a 8 pharmaceutical product through Tel-Drug, they use 9 Tel-Drug to obtain the product. From what you've told 10 me, I understand that Tel-Drug will provide that 11 product to the physician, and Tel-Drug will then seek 12 reimbursement for that product from Cigna? 13 A. That's correct. 14 Q. And Cigna will reimburse Tel-Drug? 15 A. That's correct. 16 Q. Do you know if the variation in the rates 17 that Tel-Drug is willing to accept for reimbursement 18 relate to Tel-Drug's -- relate to the cost of 19 Tel-Drug's acquisition of the product? 20 A. I do not know. 21 Q. So if I wanted to understand Tel-Drug's 22 reasoning, I would have to ask someone at Tel-Drug, I</p>
<p>23 1 one mean the reimbursement would be the Cigna national 2 standard injectable reimbursement rate? 3 A. That would be one potential, yes. 4 Q. It could be in the contract between Cigna and 5 that particular provider? 6 A. Uh-hum, yes. 7 Q. So beyond considering what Tel-Drug is 8 willing to provide in terms of reimbursement, are there 9 any other factors that go into the variation between 10 the different reimbursement rates under Cigna's 11 national standard injectable reimbursement rate? 12 A. No. As we're specifically talking about the 13 codes outside the approximate 13? 14 Q. Uh-hum. 15 A. It's for everything but those 13 codes. That 16 is all that is considered. 17 Q. And who makes that decision at Tel-Drug? 18 A. I do not know. 19 Q. And do you know how Tel-Drug makes the 20 decision of being willing to expect reimbursement at 21 AWP for some drugs and at 45 percent below AWP for 22 other drugs?</p>	<p>25 1 presume, or is there someone in your group at Cigna 2 that could tell me that? 3 MR. ST. PHILLIP: Objection. 4 A. There is not someone in my group. 5 Q. And you don't know who I would talk to at 6 Tel-Drug, or what department? 7 A. Department would be Pharmacy Operations. 8 Q. And in talking about Tel-Drug's provision of 9 their pharmaceutical products to physicians, are we 10 talking about a specialty pharmacy service that 11 Tel-Drug provides? 12 A. Could you clarify your question? 13 Q. Are you familiar with the term specialty 14 pharmacy? 15 A. Not well enough to answer your question. 16 Q. Do you know if Cigna has a specialty 17 pharmacy? 18 A. I have seen announcements. 19 MR. ST. PHILLIP: I guess I would object 20 insofar as I don't think the witness 21 understands what you mean by definition of a 22 specialty pharmacy.</p>



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<p>26</p> <p>1 But you can answer.</p> <p>2 A. There is an area in Cigna that is getting</p> <p>3 into specialty pharmacy. Exactly what specialty means,</p> <p>4 I do not understand.</p> <p>5 Q. Going back to the rate exhibits that we were</p> <p>6 discussing previously, you had testified that</p> <p>7 approximately 50 percent of the reimbursement rates for</p> <p>8 pharmaceuticals dispensed in a physician's office would</p> <p>9 be based on AWP --</p> <p>10 MR. ST. PHILLIP: Objection.</p> <p>11 Q. -- is that correct?</p> <p>12 A. That is correct.</p> <p>13 Q. And can you tell me would those rates be</p> <p>14 typically set at AWP or at a percentage off AWP or at a</p> <p>15 percentage above AWP?</p> <p>16 MR. ST. PHILLIP: In terms of -- we went</p> <p>17 through this a little bit on the pharmacy</p> <p>18 side, but in terms of the prevailing rates in</p> <p>19 the contracts today or historical rates?</p> <p>20 MS. SCHOEN: I think we're limited from</p> <p>21 2001 to the present, so that's what I'm</p> <p>22 talking about.</p>	<p>28</p> <p>1 variation between those different levels? Would this</p> <p>2 be based on, for example, negotiations with the</p> <p>3 physician groups?</p> <p>4 A. That is exactly what it's based on.</p> <p>5 Q. So some physician groups would perhaps have</p> <p>6 more bargaining power and demand higher reimbursement</p> <p>7 rates for pharmaceutical products, and some may</p> <p>8 demand -- have lesser demands?</p> <p>9 A. That is correct.</p> <p>10 Q. Is it also the case that a physician's group,</p> <p>11 in negotiations with Cigna, may seek higher</p> <p>12 reimbursement for pharmaceutical products in exchange</p> <p>13 for WAC reimbursement in a whole other area of the fee</p> <p>14 schedule of the rate exhibit?</p> <p>15 MR. ST. PHILLIP: Objection to form.</p> <p>16 You can answer.</p> <p>17 A. Could you rephrase the question.</p> <p>18 Q. Sure. Let me ask it in a different way, and</p> <p>19 maybe it will be clear.</p> <p>20 When Cigna negotiates with a physician's</p> <p>21 group, are you negotiating the entire rate schedule or</p> <p>22 rate exhibit as a whole, or are you negotiating it on a</p>
<p>27</p> <p>1 MR. ST. PHILLIP: And I would ask the</p> <p>2 witness to go back to '91 to the extent she</p> <p>3 knows or has acquired information about that</p> <p>4 or has acquired information about that --</p> <p>5 MS. SCHOEN: I think for now, since she</p> <p>6 testified her knowledge is primarily from</p> <p>7 2001 to now, we'll start there --</p> <p>8 MR. ST. PHILLIP: Fair enough.</p> <p>9 MS. SCHOEN: -- and then I can go back</p> <p>10 and explore if there's any bits of knowledge</p> <p>11 prior to that.</p> <p>12 Q. So from the period from 2001 to the present,</p> <p>13 I believe you had testified that 50 percent</p> <p>14 approximately of the rate exhibit would base</p> <p>15 reimbursement for pharmaceutical products dispensed at</p> <p>16 a physician's office on the AWP; is that correct?</p> <p>17 A. Yes.</p> <p>18 Q. And can you tell me if that reimbursement</p> <p>19 rate would be set at the average wholesale price, above</p> <p>20 the average wholesale price, or below?</p> <p>21 A. It can be set at any of those levels.</p> <p>22 Q. And can you tell me what determines the</p>	<p>29</p> <p>1 piecemeal basis?</p> <p>2 A. The negotiation is completed in whole, so</p> <p>3 negotiating all the physician's services.</p> <p>4 Q. So would it be correct to say that in some</p> <p>5 cases a physician might accept a lesser reimbursement</p> <p>6 for pharmaceutical products and instead demand a</p> <p>7 greater reimbursement for a particular service, for</p> <p>8 example?</p> <p>9 A. That can definitely happen.</p> <p>10 Q. And can you tell me the range that would</p> <p>11 exist if I were to be able to look at all the rate</p> <p>12 exhibits that Cigna has out there, the range and AWP</p> <p>13 reimbursements that may exist?</p> <p>14 A. Can you clarify your question? Are you</p> <p>15 talking about all of Cigna's rate exhibits or the rate</p> <p>16 exhibits that are based on AWP?</p> <p>17 Q. Thank you. We're talking about all of the</p> <p>18 rate exhibits that are based on AWP.</p> <p>19 A. I do not have enough knowledge to tell you</p> <p>20 what the rate is.</p> <p>21 Q. Can you give me a rough estimate?</p> <p>22 A. My rough estimate would be between 80 and</p>

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<p>1 120.</p> <p>2 Q. And the variation between the 80 and 120</p> <p>3 would be due to variability in the negotiation process</p> <p>4 with physicians?</p> <p>5 A. That's correct.</p> <p>6 Q. In your experience, do certain groups of</p> <p>7 physicians command higher reimbursement rates than</p> <p>8 others -- for example, oncologists?</p> <p>9 A. There are certain physician groups that do</p> <p>10 demand higher rates than other groups.</p> <p>11 Q. When you go into negotiations with</p> <p>12 physicians, how does Cigna decide whether the baseline</p> <p>13 will be the AWP based reimbursement that you've</p> <p>14 described or the Cigna national standard injectable</p> <p>15 reimbursement that you've described?</p> <p>16 A. It is a standard to use the Cigna national</p> <p>17 standard. The reimbursement, other than the Cigna</p> <p>18 national standard, is only on an exception basis.</p> <p>19 Q. So would it be correct to say that Cigna</p> <p>20 would like you to use its national standard rates in</p> <p>21 all negotiations and only does not use those if the</p> <p>22 physicians' groups object?</p>	<p>30</p> <p>1 negotiate with Cigna to change those rates in any way;</p> <p>2 it must accept those as is?</p> <p>3 MR. ST. PHILLIP: Objection.</p> <p>4 Q. Is that correct?</p> <p>5 A. If he accepts them, he accepts them. If he</p> <p>6 doesn't accept them, he negotiates otherwise.</p> <p>7 Q. I'm comparing -- this may be a more helpful</p> <p>8 way to get to where I'm going. Maybe I'm comparing it</p> <p>9 to the AWP example where, as I understand it from you,</p> <p>10 there is negotiation that results in different</p> <p>11 reimbursement rates.</p> <p>12 MR. ST. PHILLIP: Objection.</p> <p>13 A. Yes.</p> <p>14 Q. So comparing to -- how does Cigna's use of</p> <p>15 its national standard injectable rates compare to --</p> <p>16 (Discussion off the record.)</p> <p>17 Q. Let me try this in a new way.</p> <p>18 Is Cigna's national standard injectable</p> <p>19 reimbursement rate a take it or leave it proposition?</p> <p>20 In other words, there's no negotiation on those rates?</p> <p>21 A. When they accept the national standard,</p> <p>22 they've accepted it. If they want to negotiate</p> <p>32</p>
<p>31</p> <p>1 MR. ST. PHILLIP: Object.</p> <p>2 A. Yes.</p> <p>3 Q. And why would a physician group, if you know,</p> <p>4 why would a physician group object to the use of</p> <p>5 Cigna's national standard rates?</p> <p>6 A. Because they feel the reimbursement is</p> <p>7 inappropriate.</p> <p>8 Q. If -- does Cigna ever negotiate variations</p> <p>9 from its national standard rates? In other words,</p> <p>10 would Cigna ever present its rates to a physician as a</p> <p>11 national standard rate, and the physician and Cigna</p> <p>12 could negotiate from those rates or down from those</p> <p>13 rates?</p> <p>14 A. Not -- the negotiation does not take place</p> <p>15 that we negotiate at a percent of our national</p> <p>16 standard. That we do not do.</p> <p>17 Q. So if Cigna has a contract with a physician's</p> <p>18 group, and that rate exhibit incorporates Cigna's</p> <p>19 national standards rate, there would be no variation</p> <p>20 and -- strike that.</p> <p>21 So if a physician's group accepts</p> <p>22 Cigna's national standard rates, it is not free to then</p>	<p>33</p> <p>1 otherwise, negotiations can happen.</p> <p>2 Q. Do they happen on the basis of the national</p> <p>3 standard injectable rates or not?</p> <p>4 A. Typically not.</p> <p>5 Q. At that point, if a physician's group wants</p> <p>6 to negotiate the reimbursement rate it receives for</p> <p>7 pharmaceuticals products, then that negotiation would</p> <p>8 take place with a baseline of AWP, is that right?</p> <p>9 MR. ST. PHILLIP: Objection to form.</p> <p>10 You can answer.</p> <p>11 A. That would be very common.</p> <p>12 Q. If I were to go out and look at all of</p> <p>13 Cigna's rate exhibits, would I find anywhere -- I would</p> <p>14 see the Cigna's national standard injectable</p> <p>15 reimbursement rates minus 10 percent set as the</p> <p>16 reimbursement rate?</p> <p>17 A. Not to my knowledge.</p> <p>18 Q. Or minus any percentage?</p> <p>19 A. No, not to my knowledge.</p> <p>20 Q. Plus any percentage?</p> <p>21 A. Not to my knowledge.</p> <p>22 Q. You mentioned that there's a small amount of</p>

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<p style="text-align: right;">34</p> <p>1 reimbursement to physicians that's based on a</p> <p>2 percentage of billed charges?</p> <p>3 A. That is correct.</p> <p>4 Q. Can you tell me why Cigna reimburses based on</p> <p>5 billed charges in a small number of cases?</p> <p>6 MR. ST. PHILLIP: Objection.</p> <p>7 You can answer.</p> <p>8 A. Part of the negotiation process.</p> <p>9 Q. Would I be correct in assuming that in that</p> <p>10 negotiation process, it would be the physician who</p> <p>11 wanted to be reimbursed at a percentage of their billed</p> <p>12 charges?</p> <p>13 MR. ST. PHILLIP: Objection.</p> <p>14 A. Yes.</p> <p>15 Q. I want to turn back to what -- to your</p> <p>16 testimony earlier where you testified that there are 13</p> <p>17 J-codes, that since September 7, 2004, have been</p> <p>18 reimbursed using the different methodologies.</p> <p>19 A. Yes.</p> <p>20 Q. I believe you testified that the</p> <p>21 reimbursement for those 13 codes is based, in part, on</p> <p>22 the physician's acquisition cost, is that correct?</p>	<p style="text-align: right;">36</p> <p>1 sure that we cover physician acquisition cost, and we</p> <p>2 have chosen to add on an additional amount to make sure</p> <p>3 that we are paying above that amount in all situations.</p> <p>4 Q. So you want -- so Cigna wants to insure that</p> <p>5 physicians are having their costs, their acquisition</p> <p>6 costs covered in all cases?</p> <p>7 MR. ST. PHILLIP: Objection.</p> <p>8 Q. Is that correct?</p> <p>9 A. That is the intent.</p> <p>10 Q. Does Cigna also intend to provide physicians</p> <p>11 with a reasonable margin above the acquisition cost?</p> <p>12 A. It is not something that we have done is</p> <p>13 taken a position on what is considered reasonable, and</p> <p>14 margin, and the appropriateness of that.</p> <p>15 MR. ST. PHILLIP: Can you read that</p> <p>16 answer back.</p> <p>17 (The court reporter read back.)</p> <p>18 Q. You mentioned that of the 13 drugs for which</p> <p>19 Cigna has applied this relatively new methodology, that</p> <p>20 many of them are -- have generic equivalents.</p> <p>21 Can you tell me in a little more detail</p> <p>22 why these 13 drugs were chosen?</p>
<p style="text-align: right;">35</p> <p>1 A. Yes.</p> <p>2 Q. And can you tell me how Cigna determines the</p> <p>3 physician's acquisition cost?</p> <p>4 A. It is information that we have through</p> <p>5 working with a -- I don't know technically what they</p> <p>6 are called, but essentially they are a pharmaceutical</p> <p>7 consultant group.</p> <p>8 Q. And for those 13 J-codes, does Cigna</p> <p>9 reimburse at what it believes the physician's actual</p> <p>10 acquisition cost is?</p> <p>11 A. Yes.</p> <p>12 Q. Can you tell me instead what do you reimburse</p> <p>13 at?</p> <p>14 A. It is reimbursed at the physician acquisition</p> <p>15 cost plus 20 percent of the AWP.</p> <p>16 Q. And can you tell me the reasoning behind that</p> <p>17 reimbursement methodology?</p> <p>18 A. The reasoning is that the -- for most of</p> <p>19 those J-codes, generic equivalents have been introduced</p> <p>20 for the drugs. They have -- with the introduction of</p> <p>21 generic equivalents, the physician acquisition cost has</p> <p>22 reduced significantly, and the -- so we have to make</p>	<p style="text-align: right;">37</p> <p>1 A. The 13 drugs were chosen because the prior</p> <p>2 reimbursement methodology, which is as I described</p> <p>3 otherwise, did not appropriately reflect the changes in</p> <p>4 the market pricing over the last -- my understanding</p> <p>5 it's been a couple of years that these generics have</p> <p>6 become available, and have been introduced to drive</p> <p>7 down the acquisition cost.</p> <p>8 Q. Does Cigna look at the physician's</p> <p>9 acquisition cost for any drugs other than these 13 in</p> <p>10 setting reimbursement rates?</p> <p>11 A. No.</p> <p>12 Q. And can you tell me why not?</p> <p>13 THE WITNESS: May I clarify the scope?</p> <p>14 MS. SCHOEN: Please.</p> <p>15 MR. ST. PHILLIP: You may.</p> <p>16 A. I need to clarify that my responses have been</p> <p>17 related to injectable medications, not to vaccinations,</p> <p>18 toxoid immunizations.</p> <p>19 So would you like to ask that question?</p> <p>20 MS. SCHOEN: Can you read back the</p> <p>21 question.</p> <p>22 (The court reporter read back.)</p>

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<p>1 A. We haven't felt it's been necessary.</p> <p>2 MR. ST. PHILLIP: We've been going</p> <p>3 awhile. When you find an appropriate</p> <p>4 breaking point, we'd like to take a break.</p> <p>5 MS. SCHOEN: We can take a break now.</p> <p>6 (Recess taken.)</p> <p>7 Q. So going back to the Cigna national standard</p> <p>8 injectable reimbursement rate, those reimbursement</p> <p>9 rates are set on a drug-by-drug basis, is that correct?</p> <p>10 A. They are set by HCPCS code.</p> <p>11 Q. So they are set on a J-code by J-code basis?</p> <p>12 A. That is correct.</p> <p>13 Q. So Cigna would look at each J-code and make</p> <p>14 an individualized determination of the percentage below</p> <p>15 AWP or otherwise that it should be -- the drug -- that</p> <p>16 the J-code rather should be reimbursed at?</p> <p>17 A. Yes. Each J-code is set individually.</p> <p>18 Q. And just to make sure that I'm clear on your</p> <p>19 prior testimony, the decision of whether to reimburse</p> <p>20 based at AWP or below AWP by 15 percent or below AWP by</p> <p>21 45 percent is all made by Tel-Drug?</p> <p>22 A. Yes, I believe that is where discounts came</p>	<p>38</p> <p>1 wholesale price to use when it's determining a</p> <p>2 reimbursement by J-code?</p> <p>3 A. We obtain the average wholesale price at the</p> <p>4 J-code level. There's a methodology that the vendor --</p> <p>5 for lack of a better word -- uses to look across the</p> <p>6 NDCs and come up with the appropriate average wholesale</p> <p>7 price.</p> <p>8 Q. And when say the vendor, you mean a third</p> <p>9 party?</p> <p>10 A. Yeah. It's not within Cigna.</p> <p>11 MR. ST. PHILLIP: Could I clarify for a</p> <p>12 second?</p> <p>13 MS. SCHOEN: Sure.</p> <p>14 (Witness and counsel confer).</p> <p>15 Q. After conferring briefly with counsel, do you</p> <p>16 have any --</p> <p>17 A. Could you repeat the question.</p> <p>18 MS. SCHOEN: Can you read back the</p> <p>19 question.</p> <p>20 (The court reporter read back.)</p> <p>21 A. Yes. The third party is First Data Bank.</p> <p>22 Q. So First Data Bank provides you with an AWP</p>
<p>39</p> <p>1 from.</p> <p>2 Q. Can you think of any other place that those</p> <p>3 rates may have come from?</p> <p>4 A. Pharmacy Operations within Cigna that are</p> <p>5 technically not of the Tel-Drug subsidiary but work</p> <p>6 very closely with them.</p> <p>7 Q. And you're not aware of the factors that go</p> <p>8 into making the determination of the reimbursement</p> <p>9 rate?</p> <p>10 A. That is correct, I have no knowledge.</p> <p>11 Q. Now, we discussed briefly that one particular</p> <p>12 J-code may incorporate more than one NDC, is that</p> <p>13 correct?</p> <p>14 A. That is correct.</p> <p>15 Q. So if a physician submits a reimbursement</p> <p>16 claims form with only a J-code, under the -- how does</p> <p>17 Cigna know what reimbursement to provide?</p> <p>18 A. A reimbursement is set at the J-code level.</p> <p>19 Q. Is it true that for each NDC, there may be a</p> <p>20 different AWP?</p> <p>21 A. It is my understanding that that is correct.</p> <p>22 Q. So how does Cigna determine which average</p>	<p>41</p> <p>1 by J-code?</p> <p>2 A. That is correct.</p> <p>3 Q. And I believe you had testified that First</p> <p>4 Data Bank uses some methodology to arrive at that AWP</p> <p>5 by J-code, but you're not exactly sure of which</p> <p>6 methodology they use, is that correct?</p> <p>7 A. No. They use a methodology.</p> <p>8 My understanding of the methodology is</p> <p>9 as follows. They take all of the NDC's appropriate to</p> <p>10 bill underneath that J-code, and they break them into</p> <p>11 brand drugs and generic drugs, and take the average of</p> <p>12 the average wholesale prices of the brand drugs and the</p> <p>13 average of the average wholesale prices of the</p> <p>14 generics, and they use the lesser of the two of those</p> <p>15 numbers.</p> <p>16 Q. And if there are no generics, then I would</p> <p>17 suppose they'd just take the average of the branded</p> <p>18 drugs?</p> <p>19 A. That is my understanding, yes.</p> <p>20 Q. And so when the -- when Cigna is using the</p> <p>21 average wholesale price by J-code for its national</p> <p>22 standard injectable reimbursement rates, you're not</p>

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<p style="text-align: right;">42</p> <p>1 actually using the average wholesale price that relates</p> <p>2 to a particular NDC unless that NDC is the only NDC for</p> <p>3 a particular J-code?</p> <p>4 MR. ST. PHILLIP: Objection.</p> <p>5 You can answer.</p> <p>6 A. That is correct.</p> <p>7 Q. And going back to the other methodology for</p> <p>8 reimbursing physicians for pharmaceutical products, the</p> <p>9 AWP based methodology, is that based on J-code, or is</p> <p>10 that based on an NDC?</p> <p>11 A. I want to clarify. You're talking about the</p> <p>12 rate exhibit when it says a certain percentage of AWP,</p> <p>13 are those AWP's based on J-code versus NDC?</p> <p>14 Q. Right.</p> <p>15 A. The reimbursement is set at the HCPCS level,</p> <p>16 the J-code level.</p> <p>17 Q. So then would I be correct to say that if I</p> <p>18 looked at Cigna's rate exhibits for all pharmaceuticals</p> <p>19 that would be included under the rate exhibits, the</p> <p>20 reimbursement rate would be set by J-code, not by NDC?</p> <p>21 MR. ST. PHILLIP: Objection.</p> <p>22 A. The -- it is always done by the appropriate</p>	<p style="text-align: right;">44</p> <p>1 know for certain.</p> <p>2 Q. But the AWP's you use and First Data Bank for</p> <p>3 your rate exhibits are the ones that you've described</p> <p>4 previously where First Data Bank would average the AWP's</p> <p>5 for a J-code?</p> <p>6 MR. ST. PHILLIP: Objection. It's</p> <p>7 really been asked and answered, but if you</p> <p>8 want to elaborate --</p> <p>9 A. Yes. It's -- the AWP is set by J-code using</p> <p>10 the method described earlier about averaging the</p> <p>11 different AWP's across the NDCs.</p> <p>12 Q. Prior to 2001, are you aware of what</p> <p>13 methodologies Cigna used to reimburse providers for</p> <p>14 pharmaceutical products?</p> <p>15 MR. ST. PHILLIP: Objection to form.</p> <p>16 You can answer.</p> <p>17 A. In my conversations with colleagues who have</p> <p>18 knowledge about that time, it is my understanding that</p> <p>19 the reimbursement was as I have described, meaning that</p> <p>20 it's per the contracting terms. It's -- those</p> <p>21 contracting terms can take on different forms.</p> <p>22 Prior to 2002, the national standard did</p>
<p style="text-align: right;">43</p> <p>1 coding. It's not done by NDC. It is done by HCPCS</p> <p>2 code or CPT code, whatever is appropriate for the</p> <p>3 physician to bill according to the industry standard</p> <p>4 coding requirements.</p> <p>5 Q. So in the approximate 50 percent of the cases</p> <p>6 where the rate exhibit is based on an AWP based</p> <p>7 reimbursement, is the AWP referenced in that</p> <p>8 reimbursement the AWP for a particular J-code, or is it</p> <p>9 the AWP for a particular NDC?</p> <p>10 A. AWP for a particular J-code.</p> <p>11 Q. So once again, if there are multiple NDCs for</p> <p>12 a particular J-code, the AWP that would be used would</p> <p>13 be determined by First Data Bank, as you have</p> <p>14 described, by averaging the different AWP's for the</p> <p>15 different NDCs in that J-code, is that correct?</p> <p>16 A. When we have a contract that we base the</p> <p>17 reimbursement of injectables as a percentage of AWP,</p> <p>18 those AWP amounts come from the First Data Bank.</p> <p>19 Q. Are you aware that First Data Bank provides</p> <p>20 AWP's by NDC?</p> <p>21 MR. ST. PHILLIP: Objection.</p> <p>22 A. I can only assume that they do. I do not</p>	<p style="text-align: right;">45</p> <p>1 not exist, so that would not have been an option. So</p> <p>2 the options prior to that would have just been AWP</p> <p>3 based and percentable charges.</p> <p>4 Q. If I were to go to the claims data for Aetna,</p> <p>5 would -- how would I tell if a particular reimbursement</p> <p>6 was based on AWP or it was based on a percent of billed</p> <p>7 charges?</p> <p>8 MR. WADE: You asked if she went to an</p> <p>9 Aetna claim.</p> <p>10 MS. SCHOEN: Excuse me?</p> <p>11 MR. WADE: You asked if she went to an</p> <p>12 Aetna claim.</p> <p>13 MS. SCHOEN: I'm sorry, I don't mean</p> <p>14 Aetna. I mean Cigna.</p> <p>15 A. By looking at a claim, you could not tell.</p> <p>16 Q. So can you just describe to me what I would</p> <p>17 have to do to find that out?</p> <p>18 A. You would have to find out what the</p> <p>19 contracting terms are.</p> <p>20 Q. Prior to 2002, do you have an idea of what</p> <p>21 percentage of reimbursement to providers was based upon</p> <p>22 the percent of billed charges as opposed to AWP?</p>



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13 (Pages 46 to 49)

<p>46</p> <p>1 A. I do not know.</p> <p>2 Q. Do you know if that percentage would have</p> <p>3 changed over time from 1991 to 2002?</p> <p>4 A. I do not know.</p> <p>5 Q. Does Aetna --</p> <p>6 MR. ST. PHILLIP: Cigna.</p> <p>7 MS. SCHOEN: Sorry.</p> <p>8 Q. Does Cigna have any -- strike that.</p> <p>9 Does Cigna make any attempts to</p> <p>10 encourage physicians to utilize Tel-Med -- Tel-Drug?</p> <p>11 MR. ST. PHILLIP: Objection to form.</p> <p>12 A. Yes.</p> <p>13 Q. And can you tell me how Cigna does that?</p> <p>14 A. Through written communications to the</p> <p>15 providers.</p> <p>16 Q. Any other ways?</p> <p>17 A. I do not know for certain, but I would expect</p> <p>18 that it was included within the Website that we have</p> <p>19 for the practitioners.</p> <p>20 Q. But Cigna does not require physicians to use</p> <p>21 the Tel-Drug service?</p> <p>22 A. That is correct.</p>	<p>48</p> <p>1 A. No.</p> <p>2 Oh, I do have to clarify that one. On</p> <p>3 injectables, no. On the immunizations, we have more</p> <p>4 recently, very recently actually, tried to get</p> <p>5 information by talking with the manufacturers of the</p> <p>6 immunizations that are able to sell directly to the</p> <p>7 doctors. Some manufacturers do that and others do not.</p> <p>8 Q. So in those cases, you might have been able</p> <p>9 to obtain estimates of what the physician's office</p> <p>10 might pay for the drugs?</p> <p>11 A. Yes.</p> <p>12 Q. Have you ever undertaken a similar inquiry</p> <p>13 with regard to injectables?</p> <p>14 A. No.</p> <p>15 Q. And do you know why not?</p> <p>16 A. No.</p> <p>17 Q. Do you know if -- strike that.</p> <p>18 Have you ever looked at the prices that</p> <p>19 Tel-Drug pays for injectables?</p> <p>20 A. No. I have no knowledge what Tel-Drug's</p> <p>21 acquisition costs are.</p> <p>22 Q. Have you ever considered asking Tel-Drug what</p>
<p>47</p> <p>1 Q. When the rate -- when the reimbursement for</p> <p>2 pharmaceutical products and the rate exhibit is based</p> <p>3 on average wholesale price, is that reimbursement rate</p> <p>4 set for all drugs together as a lumped unit, or would</p> <p>5 certain individualized drugs sometimes be subject to</p> <p>6 separate negotiations and have a separate reimbursement</p> <p>7 rate?</p> <p>8 MR. ST. PHILLIP: Objection to form.</p> <p>9 A. I understand, from what I have seen in</p> <p>10 contracts, all the injectables would be reimbursed at</p> <p>11 the same percent AWP. I have not seen a contract where</p> <p>12 we've varied that percentage by particular J-code.</p> <p>13 Q. And what other categories of drugs would</p> <p>14 there be in the rate exhibits besides the injectables</p> <p>15 that you've referred to?</p> <p>16 A. Immunizations and vaccinations.</p> <p>17 Q. Any others?</p> <p>18 A. No.</p> <p>19 Q. Do you have an understanding of why</p> <p>20 physicians pay for the drugs that they may administer</p> <p>21 in an office?</p> <p>22 MR. ST. PHILLIP: Objection.</p>	<p>49</p> <p>1 its acquisitions costs were in order to utilize that</p> <p>2 information in negotiations with physicians?</p> <p>3 MR. ST. PHILLIP: Objection.</p> <p>4 A. I personally have not considered that, but</p> <p>5 it's possible perhaps that people that were involved</p> <p>6 prior to my tenure might have considered that.</p> <p>7 Q. Would that yield information that would be</p> <p>8 useful in negotiations with physicians?</p> <p>9 MR. ST. PHILLIP: I'm just going to</p> <p>10 object insofar as there's been no foundation</p> <p>11 of the corporate relationship, and so the</p> <p>12 control between the various companies, and</p> <p>13 there hasn't been any foundation for that, so</p> <p>14 go ahead.</p> <p>15 MS. SCHOEN: The witness did testify</p> <p>16 that Tel-Drug was a subsidiary of Cigna.</p> <p>17 MR. ST. PHILLIP: The witness hasn't</p> <p>18 been authorized to testify about the</p> <p>19 corporate structure, so to the extent that</p> <p>20 testimony has been given, it hasn't been</p> <p>21 consented to by the company.</p> <p>22 MS. SCHOEN: I'll start -- I'll ask a</p>



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<p style="text-align: right;">50</p> <p>1 new question.</p> <p>2 Q. Is the reason that Cigna has not acquired</p> <p>3 this information from Tel-Drug because the information</p> <p>4 would, in fact, not be useful in its negotiations with</p> <p>5 providers?</p> <p>6 A. No.</p> <p>7 Q. Then what would the reason be?</p> <p>8 A. We haven't done it. We haven't — it hasn't</p> <p>9 been a consideration.</p> <p>10 Q. But presumably if it would yield savings for</p> <p>11 Cigna, in pharmaceutical reimbursement, you would have</p> <p>12 done that?</p> <p>13 MR. ST. PHILLIP: I ask the witness not</p> <p>14 to guess.</p> <p>15 A. If we knew Tel-Drug's acquisition costs, it</p> <p>16 would just be another factor to consider in setting</p> <p>17 reimbursement. It's not that it would necessarily</p> <p>18 impact the reimbursement to physicians, because there</p> <p>19 may be other valid reasons why we should sell it at a</p> <p>20 different level. So there may or may not be savings</p> <p>21 from knowing what Tel-Drug's acquisitions costs are.</p> <p>22 Q. I think that you were telling me earlier</p>	<p style="text-align: right;">52</p> <p>1 maintained so that we can then call for their</p> <p>2 production.</p> <p>3 MR. ST. PHILLIP: That's okay. We don't</p> <p>4 consent to have this witness testify about</p> <p>5 that.</p> <p>6 MS. SCHOEN: Are you instructing her not</p> <p>7 to answer this question?</p> <p>8 MR. ST. PHILLIP: No.</p> <p>9 THE WITNESS: Can you repeat the</p> <p>10 question, please.</p> <p>11 (The court reporter read back.)</p> <p>12 A. It has a standard business practice to</p> <p>13 maintain contracts with providers.</p> <p>14 Q. And can you tell me where those contracts are</p> <p>15 maintained, if you know?</p> <p>16 MR. ST. PHILLIP: Same objection.</p> <p>17 A. No response on that one.</p> <p>18 Q. You don't know?</p> <p>19 A. I don't have enough information to respond.</p> <p>20 Q. Are you aware that some injectable products</p> <p>21 can be obtained through a retail pharmacy network?</p> <p>22 A. No, I do not have good knowledge about how</p>
<p style="text-align: right;">51</p> <p>1 about the competitive nature of negotiations.</p> <p>2 Would the competitive nature of</p> <p>3 negotiations be one reason why that information may not</p> <p>4 be — may not impact the ultimate reimbursement rate?</p> <p>5 A. Certainly.</p> <p>6 Q. Does Cigna maintain its contracts with</p> <p>7 providers in the regular occurrence of its business?</p> <p>8 MR. ST. PHILLIP: I'm going to object.</p> <p>9 The deposition topic No. 25 which reads, the</p> <p>10 authentication and knowledge of all documents</p> <p>11 produced in response to Defendants' subpoena,</p> <p>12 and the extent to which such production is</p> <p>13 responsive to the Defendants' demands was</p> <p>14 excluded by the Magistrate Judge's ruling.</p> <p>15 As a result, Cigna does not consent to</p> <p>16 have this witness testify concerning the</p> <p>17 authentication of documents.</p> <p>18 MS. SCHOEN: Well, unfortunately at this</p> <p>19 stage, we have no documents to authenticate</p> <p>20 because Cigna has produced no contracts with</p> <p>21 providers. So I'm trying to determine</p> <p>22 whether such contracts exist and are</p>	<p style="text-align: right;">53</p> <p>1 physicians acquire their injectables.</p> <p>2 MR. ST. PHILLIP: Can we confer for a</p> <p>3 second?</p> <p>4 MS. SCHOEN: Sure.</p> <p>5 (Witness and counsel confer).</p> <p>6 A. Counsel has clarified what he thought the</p> <p>7 question was. So let me say that it is my</p> <p>8 understanding that people can go to the local pharmacy</p> <p>9 and get certain injectable medications.</p> <p>10 Q. And do you have an understanding whether the</p> <p>11 reimbursement that Cigna would provide to the</p> <p>12 pharmacist for dispensing that injectable medication</p> <p>13 would be the same as the reimbursement that Cigna would</p> <p>14 provide to a provider who dispensed that and</p> <p>15 administered that injectable medication?</p> <p>16 MR. ST. PHILLIP: Objection.</p> <p>17 A. I do not know.</p> <p>18 Q. And would a variation between those two rates</p> <p>19 be a product of what you've described to me earlier as</p> <p>20 the negotiation process with a physician's group that</p> <p>21 results in varying rates of reimbursement?</p> <p>22 MR. ST. PHILLIP: Objection. Lack of</p>

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15 (Pages 54 to 57)

<p>1 foundation. It calls for speculation.</p> <p>2 You can answer.</p> <p>3 A. There are negotiations with provider groups,</p> <p>4 and there are also negotiations with pharmacies, and</p> <p>5 those negotiations will yield the appropriate result</p> <p>6 for reimbursement, and I know on the physician's side,</p> <p>7 it does mean there are varying levels of reimbursement</p> <p>8 for the same services to different physicians.</p> <p>9 Q. When did you first become familiar with the</p> <p>10 term average wholesale price?</p> <p>11 A. It was -- I would have become familiar with</p> <p>12 average wholesale price either during the time I was in</p> <p>13 college or in taking the actuarial exams, so prior to</p> <p>14 1996.</p> <p>15 Q. And can you tell me what your current</p> <p>16 understanding of AWP is?</p> <p>17 A. My current understanding about what average</p> <p>18 wholesale price is, it's a number that's used as a</p> <p>19 benchmark, but I do not have -- and it's a very</p> <p>20 frequently used benchmark in the pharmaceutical</p> <p>21 industry. I do not know specifics about how it was</p> <p>22 calculated.</p>	<p>54</p> <p>1 there's a relationship between the average wholesale</p> <p>2 price and Cigna's acquisition cost for pharmaceutical</p> <p>3 products?</p> <p>4 MR. ST. PHILLIP: All pharmaceutical</p> <p>5 products?</p> <p>6 MS. SCHOEN: Let's start with all, and</p> <p>7 then we can -- if you only know for</p> <p>8 injectables, then that's where we'll go.</p> <p>9 A. In what I do, that is outside the scope of</p> <p>10 what I do, because I work on the reimbursement to</p> <p>11 practitioners. I'm not involved with the acquisition</p> <p>12 of pharmaceutical drugs and do not have that particular</p> <p>13 knowledge that is relative to the pharmacy operations</p> <p>14 area.</p> <p>15 Q. So when you, in your work, use the average</p> <p>16 wholesale price as a benchmark, you don't have any</p> <p>17 expectation that it bears any particular relationship</p> <p>18 with the actual acquisitions costs because that's a</p> <p>19 separate thing --</p> <p>20 MR. ST. PHILLIP: Objection to form.</p> <p>21 Q. -- is that correct?</p> <p>22 A. Yeah. I do not know that the acquisition</p>
<p>55</p> <p>1 Q. Are you familiar with the term wholesalers</p> <p>2 acquisition cost or WAC?</p> <p>3 A. I have become familiar with that term.</p> <p>4 Q. Do you have any understanding of whether</p> <p>5 there's a relationship between a WAC price and an AWP</p> <p>6 price for a particular drug?</p> <p>7 A. My limited exposure is that there is not a</p> <p>8 consistent relationship between WAC and AWP across the</p> <p>9 NDCs. So in other words, I do not think that WAC is</p> <p>10 always a set percentage of AWP and all NDCs.</p> <p>11 Q. Do you have any understanding of whether the</p> <p>12 AWP bears any relationship to the actual acquisition</p> <p>13 cost of drugs?</p> <p>14 MR. ST. PHILLIP: Object to the form.</p> <p>15 A. Whose acquisition cost?</p> <p>16 Q. Acquisition costs generally.</p> <p>17 MR. ST. PHILLIP: If you can answer</p> <p>18 that, go ahead.</p> <p>19 A. I don't think I can answer that one.</p> <p>20 Q. What about Cigna's acquisition costs?</p> <p>21 A. Can you please restate the whole question?</p> <p>22 Q. Do you have any understanding as to whether</p>	<p>57</p> <p>1 cost has a consistent relationship to the AWP. My</p> <p>2 understanding is that the acquisition cost is either</p> <p>3 less than or equal to the AWP.</p> <p>4 Q. And where is that understanding from?</p> <p>5 A. That understanding comes from my exposure to</p> <p>6 AWP through my education and training, and really</p> <p>7 through, over the last couple of years, just being</p> <p>8 around and listening to what's going on in the industry</p> <p>9 and what's going on at Cigna.</p> <p>10 Q. Do you have any involvement or understanding</p> <p>11 of the reimbursement provided by Cigna to hospitals for</p> <p>12 pharmaceuticals administered in the hospital outpatient</p> <p>13 department?</p> <p>14 A. That reimbursement would be based on the</p> <p>15 contractual terms.</p> <p>16 Q. So once again, it would be based on rates</p> <p>17 that were determined through a process of negotiation</p> <p>18 with a hospital and a hospital group?</p> <p>19 A. Yes.</p> <p>20 Q. To your knowledge, has Cigna ever experienced</p> <p>21 a situation where a physician's practice group</p> <p>22 projected Cigna's rate exhibit rates?</p>

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<p style="text-align: right;">58</p> <p>1 A. There have been physician groups that have</p> <p>2 not accepted our proposed rate exhibits.</p> <p>3 Q. And what happens then?</p> <p>4 A. Either we come up with a new proposal through</p> <p>5 the negotiation process or the provider -- we do not</p> <p>6 contract with the provider, so they are not a part of</p> <p>7 our network.</p> <p>8 Q. And what determines which approach Cigna</p> <p>9 takes?</p> <p>10 MR. ST. PHILLIP: Objection.</p> <p>11 A. What is the group demanding; how much level</p> <p>12 of reimbursement is affordable; and is there a</p> <p>13 particular need for that provider group in our network,</p> <p>14 because certain specialties where we make sure we have</p> <p>15 to have certain physicians -- a certain number of</p> <p>16 physicians in our networks to insure an appropriate</p> <p>17 access of care for our members.</p> <p>18 Q. So would it be correct to say that in order</p> <p>19 to provide a plan that is -- that appeals to clients</p> <p>20 like employer groups, Cigna has to work to maintain a</p> <p>21 comprehensive network of providers?</p> <p>22 MR. ST. PHILLIP: Objection.</p>	<p style="text-align: right;">60</p> <p>1 Cigna network.</p> <p>2 A. Yes. I'm sure there have been situations</p> <p>3 where provider groups have approached us to become</p> <p>4 members of the Cigna network.</p> <p>5 Q. Are you aware of whether Cigna provides</p> <p>6 reimbursement for the administration of a particular</p> <p>7 drug in a physician's office?</p> <p>8 A. We do, at least during my tenure and my</p> <p>9 knowledge. Prior to like the 2001 time frame, I do not</p> <p>10 have knowledge.</p> <p>11 Q. When Cigna considers the reimbursement for</p> <p>12 deposition administration fee for service, can you tell</p> <p>13 me how that fits into the negotiation process that</p> <p>14 we've been discussing?</p> <p>15 MR. ST. PHILLIP: I'm just going to make</p> <p>16 an objection based on the exclusion of</p> <p>17 deposition topic No. 15, which deals with the</p> <p>18 area of negotiation between the reimbursement</p> <p>19 of the drug itself and the administrative</p> <p>20 service. The question is not precisely in</p> <p>21 there, so I'll allow the witness to answer</p> <p>22 it, but you're getting close.</p>
<p style="text-align: right;">59</p> <p>1 A. To have sellable products, we do have to work</p> <p>2 to maintain competitive networks.</p> <p>3 Q. Does Cigna ever approach a physician's group</p> <p>4 with a take it or leave it contract? In other words,</p> <p>5 here's what our offer is, and we won't deviate from it</p> <p>6 at all?</p> <p>7 A. Yeah.</p> <p>8 Q. Can you tell me approximately in what</p> <p>9 percentage of cases does that happen as opposed to the</p> <p>10 negotiation process?</p> <p>11 MR. ST. PHILLIP: Over what period of</p> <p>12 time?</p> <p>13 MS. SCHOEN: Well, let's start with 2001</p> <p>14 through the present.</p> <p>15 A. I do not know.</p> <p>16 Q. Are you familiar with -- strike that.</p> <p>17 Do providers -- physician's groups or</p> <p>18 physicians solicit bids from Cigna?</p> <p>19 MR. ST. PHILLIP: Objection.</p> <p>20 A. What do you mean by bid?</p> <p>21 Q. Say a proposal for a contract between Cigna</p> <p>22 and that group, for that group to become a part of the</p>	<p style="text-align: right;">61</p> <p>1 A. The reimbursement with our provider groups,</p> <p>2 when negotiating, is considered in total, so it's the</p> <p>3 final total contract that may be decided -- that will</p> <p>4 be decided upon, and there are trade-offs made between</p> <p>5 the different services as you go through the process of</p> <p>6 negotiation and compromise to get to a solution that is</p> <p>7 agreeable to both parties.</p> <p>8 Q. And would that statement be true for all of</p> <p>9 the line items in the rate exhibit?</p> <p>10 MR. ST. PHILLIP: Objection.</p> <p>11 Q. In other words, you're looking at all the</p> <p>12 line items in a rate exhibit together and the total</p> <p>13 package -- not pulling out one line and just looking at</p> <p>14 that -- pulling out one segment and looking at that?</p> <p>15 MR. ST. PHILLIP: Same objection.</p> <p>16 A. The negotiations are done looking across the</p> <p>17 entire range of services that the provider groups</p> <p>18 provide to the members, and during those negotiations</p> <p>19 there are trade-offs to get to a final compromise</p> <p>20 solution between ourselves and the provider group, and</p> <p>21 during those negotiation discussions, it is -- it very</p> <p>22 much happens that they talk about an individual line</p>

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<p>1 item.</p> <p>2 But when the bottom line is set, it's</p> <p>3 what is the overall level of reimbursement. That's</p> <p>4 what both parties have to get comfortable with.</p> <p>5 Q. So could there ever be a case where Cigna may</p> <p>6 agree to a higher reimbursement for the -- for</p> <p>7 injectable drugs, for example, and -- in exchange for a</p> <p>8 lower reimbursement for the physician's administrative</p> <p>9 fee?</p> <p>10 MR. ST. PHILLIP: I think actually that</p> <p>11 question is right at the heart of this, so</p> <p>12 we'll object based on Magistrate Judge's</p> <p>13 exclusion in paragraph 15. But I'll allow</p> <p>14 the witness to answer the question and</p> <p>15 preserve our right to move to strike.</p> <p>16 MS. SCHOEN: For the record, we clearly</p> <p>17 disagree on that, but to move things along --</p> <p>18 A. That could be a potential trade-off that does</p> <p>19 happen during the negotiation process.</p> <p>20 Q. From 2001 to the present, do any of the</p> <p>21 reimbursement rates that Cigna uses rely on Medicare's</p> <p>22 reimbursement rates?</p>	<p>62</p> <p>1 group purchases the pharmaceutical products from a</p> <p>2 wholesaler or a manufacturer?</p> <p>3 A. No, I do not know.</p> <p>4 Q. Have you ever considered looking at the --</p> <p>5 that physician group's acquisition costs for</p> <p>6 pharmaceutical products?</p> <p>7 A. No.</p> <p>8 Q. We spoke earlier about the average wholesale</p> <p>9 price and about pricing reporters generally like First</p> <p>10 Data Bank?</p> <p>11 A. Yes.</p> <p>12 Q. Do you know of other pricing reporters</p> <p>13 besides First Data Bank?</p> <p>14 A. I've heard of the name Redbook, and I'm aware</p> <p>15 that our pharmacy area uses a system called Argus, but</p> <p>16 I've recently learned that the numbers in Argus for AWP</p> <p>17 are from First Data Bank.</p> <p>18 Q. Do you have an understanding that the AWP's</p> <p>19 for a particular drug may be different in First Data</p> <p>20 Bank versus Redbook?</p> <p>21 MR. ST. PHILLIP: Objection.</p> <p>22 A. Yes. I have learned that they are different.</p>
<p>63</p> <p>1 A. For what services are you asking that</p> <p>2 question of?</p> <p>3 Q. In particular, drugs?</p> <p>4 A. We have not based our reimbursement of any</p> <p>5 injectable medications based on what Medicare pays.</p> <p>6 MR. WADE: Estella, I'm sorry to</p> <p>7 interrupt you. How much longer do you think</p> <p>8 you'll be with Jill?</p> <p>9 (Discussion off the record.)</p> <p>10 (Recess deposition at 3:00 PM.)</p> <p>11 (Deposition resumed at 4:05 PM.)</p> <p>12 Q. Do you know if Cigna owns any physician</p> <p>13 groups?</p> <p>14 A. Yes, one.</p> <p>15 Q. And can you tell me where that group is</p> <p>16 located?</p> <p>17 A. Phoenix, Arizona.</p> <p>18 Q. And has -- do you know how the physicians in</p> <p>19 that physician group acquire pharmaceutical products</p> <p>20 that they administer to patients?</p> <p>21 A. I have no idea.</p> <p>22 Q. You don't know whether they -- that physician</p>	<p>64</p> <p>1 Q. Can you tell me how you learned that?</p> <p>2 A. Because we've had contractors -- provider</p> <p>3 groups have come back to our contractors who have</p> <p>4 called me and have told me such, because they like to</p> <p>5 quote a different number as AWP when trying to</p> <p>6 negotiate to the right amount.</p> <p>7 Q. So in the negotiation process, in the context</p> <p>8 of a negotiation process, a provider might tell you or</p> <p>9 someone else at Cigna that the Redbook has a different</p> <p>10 AWP than First Data Bank; is that what you're saying?</p> <p>11 A. I don't think they necessarily tell us that</p> <p>12 the numbers are different, but they quote an AWP</p> <p>13 number, and we tell them it's not the same as ours or</p> <p>14 we tell them it is the same as ours.</p> <p>15 Q. But the AWP that Cigna uses is always the</p> <p>16 First Data Bank AWP?</p> <p>17 A. That is correct.</p> <p>18 Q. Do you have any other knowledge of why First</p> <p>19 Data Bank might have a different average wholesale</p> <p>20 price listed than another pricing service?</p> <p>21 A. No.</p> <p>22 Q. Earlier we also spoke of your understanding</p>

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18 (Pages 66 to 69)

<p>66</p> <p>1 of the term average wholesale price.</p> <p>2 I wonder if you could tell me if your</p> <p>3 understanding of that term has changed at all over time</p> <p>4 or has it been static?</p> <p>5 A. It's been pretty static. I can't -- when I</p> <p>6 first learned about AWP through my studies in my very</p> <p>7 early career when I started becoming more involved, it</p> <p>8 had the same meaning to me.</p> <p>9 Q. And how is AWP relevant to your studies?</p> <p>10 A. To pass my actuarial exam, we had to have</p> <p>11 some basic understanding of products, healthcare</p> <p>12 products, life insurance products and different things,</p> <p>13 so there's a lot of -- wide scope of knowledge that you</p> <p>14 have to pass the exams.</p> <p>15 Q. So this was a general actuarial exam, but it</p> <p>16 required some particularized knowledge about the</p> <p>17 healthcare industry?</p> <p>18 A. Yes.</p> <p>19 Q. And I believe you testified earlier that you</p> <p>20 don't know the prices that pharmacies may pay to</p> <p>21 acquire injectable drugs; is that fair?</p> <p>22 A. That's correct.</p>	<p>68</p> <p>1 Q. Sure. I'll rephrase it.</p> <p>2 Isn't it correct that when Cigna</p> <p>3 reimburses a provider for a pharmaceutical product,</p> <p>4 that Cigna will presume that that provider has</p> <p>5 purchased that product for a price that's less than</p> <p>6 what the reimbursement is?</p> <p>7 MR. ST. PHILLIP: Same objection.</p> <p>8 A. We like to be able to cover the physician's</p> <p>9 acquisition cost. However, we are operating in a</p> <p>10 competitive industry, and if the physicians are not</p> <p>11 purchasing at lower rates that are available in the</p> <p>12 market, so they're paying an amount that's higher than</p> <p>13 they can buy the same thing from somebody else, then</p> <p>14 it's potentially possible that our reimbursement can be</p> <p>15 less than their acquisition cost, because we are a</p> <p>16 competitor market driven company. It's the marketplace</p> <p>17 we operate in.</p> <p>18 Q. And any such loss that the provider may incur</p> <p>19 for a pharmaceutical product, reimbursement could</p> <p>20 potentially be made up by Cigna's reimbursement to that</p> <p>21 provider for another line item on the rate exhibit;</p> <p>22 isn't that correct?</p>
<p>67</p> <p>1 Q. Do you have any understanding of -- strike</p> <p>2 that.</p> <p>3 Do you have any understanding of whether</p> <p>4 the price that pharmacies pay for injectable drugs</p> <p>5 bears any relationship to the average wholesale price?</p> <p>6 A. I'm sorry, you asked if I understand if the</p> <p>7 acquisition cost of what group? Pharmacies?</p> <p>8 Q. The acquisition costs of injectable drugs by</p> <p>9 pharmacies bears any relationship to the average</p> <p>10 wholesale price?</p> <p>11 A. It is my understanding that there is no</p> <p>12 consistent relationship to average wholesale price, but</p> <p>13 that acquisition of drugs by pharmacy's providers is</p> <p>14 typically at less than or equal to the average</p> <p>15 wholesale price.</p> <p>16 Q. At the same time you presume that pharmacies</p> <p>17 are -- providers are acquiring the pharmaceutical</p> <p>18 products at a price that's less than the price that</p> <p>19 Cigna reimburses that provider?</p> <p>20 MR. ST. PHILLIP: Objection.</p> <p>21 Don't presume.</p> <p>22 A. I'm not sure I understand the whole question.</p>	<p>69</p> <p>1 MR. ST. PHILLIP: Objection. Calls for</p> <p>2 speculation.</p> <p>3 A. That is correct.</p> <p>4 Q. Have some providers threatened to leave the</p> <p>5 Cigna network during the negotiation process around the</p> <p>6 rate exhibit reimbursement rates?</p> <p>7 A. That can happen during negotiations, yes.</p> <p>8 Q. And like you testified earlier, would that</p> <p>9 either lead Cigna to offer perhaps a higher</p> <p>10 reimbursement rate or lead Cigna to tell the physicians</p> <p>11 group that the rates are nonnegotiable?</p> <p>12 MR. ST. PHILLIP: Objection.</p> <p>13 A. If the provider is unsatisfied with the</p> <p>14 reimbursement, there could be other alternatives</p> <p>15 negotiated, or there may not be a contract with that</p> <p>16 provider.</p> <p>17 Q. You've testified that in your current role,</p> <p>18 one of your many functions is to analyze the</p> <p>19 reimbursement rates provided to providers?</p> <p>20 A. That is correct.</p> <p>21 Q. And can you tell me a little bit more about</p> <p>22 what type of analysis that you engage in?</p>



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19 (Pages 70 to 73)

<p>70</p> <p>1 A. The analysis that we do is to look at part</p> <p>2 reimbursement as well as proposed reimbursement and how</p> <p>3 much of an increase that is going to be, and what is</p> <p>4 that overall impact going to be on the amount of costs</p> <p>5 for our members.</p> <p>6 Q. Do you do that analysis on a physician's</p> <p>7 group by physician's group basis?</p> <p>8 A. That is done, yes, basically a physician</p> <p>9 group-by-physician group. It's whenever we have a</p> <p>10 negotiation. We could end up doing multiple analyses</p> <p>11 depending on how many different scenarios there are</p> <p>12 within the negotiations that we have.</p> <p>13 Q. So if there are different rounds of</p> <p>14 negotiations that lead to different offers for rate</p> <p>15 exhibits on the table, you might do an analysis for</p> <p>16 each different rate exhibit before it's offered?</p> <p>17 A. Yes.</p> <p>18 Q. And are you looking at any in the -- in your</p> <p>19 analysis, are you looking at any information that would</p> <p>20 let you know whether the rates that you're considering</p> <p>21 offering this provider are competitive in the</p> <p>22 marketplace?</p>	<p>72</p> <p>1 MR. ST. PHILLIP: What time frame?</p> <p>2 MS. SCHOEN: Let's start with currently.</p> <p>3 A. I do not know.</p> <p>4 Q. What about historically? Do you know if</p> <p>5 Cigna has, in the past, received rebates from</p> <p>6 pharmaceutical manufacturers for injectable products?</p> <p>7 A. I do not know.</p> <p>8 Q. In the negotiation process with physicians</p> <p>9 groups, who are Cigna's competitors?</p> <p>10 MR. ST. PHILLIP: Objection.</p> <p>11 You can answer.</p> <p>12 A. Our competitors are the carriers who are</p> <p>13 providing health care insurance coverage to other</p> <p>14 members, to other people in the population. So there's</p> <p>15 numerous competitors out there.</p> <p>16 Q. Do you see pharmacy benefit managers as</p> <p>17 competitors in this negotiation process with</p> <p>18 physicians?</p> <p>19 MR. ST. PHILLIP: Objection.</p> <p>20 A. No, I do not see them as competitors as it</p> <p>21 relates to a relationship with physicians.</p> <p>22 Q. I may have asked you this already, but given</p>
<p>71</p> <p>1 A. Well, sometimes as part of our analysis, we</p> <p>2 will look at what we are reimbursing other physicians</p> <p>3 for the same services to help us understand is that</p> <p>4 competitive with our other negotiations. My team can do</p> <p>5 that.</p> <p>6 Contract negotiators might have</p> <p>7 discussions with providers about our reimbursement</p> <p>8 versus the reimbursement that they might get from</p> <p>9 another carrier.</p> <p>10 Q. And would Cigna take into account what the</p> <p>11 providers have told them about what they may be getting</p> <p>12 from another carrier?</p> <p>13 A. Indirectly, yes. As it -- we make the</p> <p>14 decisions -- it's really the outcome about what the</p> <p>15 provider is going to be reimbursed is the outcome of</p> <p>16 the negotiation process. It's back and forth, give and</p> <p>17 take, and there's many factors to consider.</p> <p>18 Q. Are injectable drugs included on the Cigna</p> <p>19 formulary?</p> <p>20 A. I do not know.</p> <p>21 Q. Do you know whether Cigna receives rebates</p> <p>22 from pharmaceutical manufacturers for injectable drugs?</p>	<p>73</p> <p>1 the time lapse, I'll go ahead and ask you again.</p> <p>2 Do you have any understanding of whether</p> <p>3 providers may receive rebates from pharmaceutical</p> <p>4 manufacturers for injectable drugs?</p> <p>5 A. I do not know.</p> <p>6 Q. What about for any other type of drugs that a</p> <p>7 physician may administer in the physician's office?</p> <p>8 A. I do not know.</p> <p>9 Q. I believe you testified that it's your</p> <p>10 understanding that providers may pay the average</p> <p>11 wholesale price or some percentage below that for</p> <p>12 pharmaceutical products administered in their office,</p> <p>13 correct?</p> <p>14 MR. ST. PHILLIP: Objection.</p> <p>15 A. Could you please repeat the question.</p> <p>16 Q. I believe it was your testimony that</p> <p>17 providers pay average wholesale price or some</p> <p>18 percentage below average wholesale price for</p> <p>19 pharmaceutical products administered in an office, is</p> <p>20 that correct?</p> <p>21 A. That's my understanding.</p> <p>22 Q. Are you familiar with the term wholesaler's</p>



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20 (Pages 74 to 77)

<p style="text-align: right;">74</p> <p>1 acquisition costs?</p> <p>2 A. Yes.</p> <p>3 Q. And what is your understanding of that term?</p> <p>4 A. That it is -- it represents a rate amount</p> <p>5 that is supposed to be the wholesaler's acquisition</p> <p>6 cost, but exactly how it all gets calculated, I do not</p> <p>7 know. What I do know about it is that it -- every</p> <p>8 situation -- I've never known it to be above AWP, so</p> <p>9 less than AWP, but exactly what the number is doesn't</p> <p>10 have a direct relationship with AWP.</p> <p>11 Q. Would you say that Cigna has an understanding</p> <p>12 that providers need to make a profit margin in order to</p> <p>13 stay in business?</p> <p>14 MR. ST. PHILLIP: Objection.</p> <p>15 A. Your question was if providers need a profit</p> <p>16 margin to stay in business?</p> <p>17 Q. Is that correct?</p> <p>18 A. Yes.</p> <p>19 Q. And that as a general matter, Cigna assumes</p> <p>20 that the reimbursement rates that it provides providers</p> <p>21 will allow the physicians to make a fair and reasonable</p> <p>22 margin and stay in business; isn't that correct?</p>	<p style="text-align: right;">76</p> <p>1 administered in a hospital outpatient department, does</p> <p>2 Cigna have any preference over the site of care?</p> <p>3 MR. ST. PHILLIP: Objection, insofar as</p> <p>4 it calls for an across the board answer. Go</p> <p>5 ahead.</p> <p>6 A. The answer to that is that our preference, if</p> <p>7 it was medically appropriate to do so, for that</p> <p>8 injectable to be administered in a physician's office</p> <p>9 because it generally is better for the member as well</p> <p>10 as the lower medical costs.</p> <p>11 Q. And do you know why there are lower medical</p> <p>12 costs in a physician's office as opposed to a hospital</p> <p>13 outpatient department?</p> <p>14 A. That would be because of the overhead and</p> <p>15 facility costs that is associated with the outpatient</p> <p>16 facilities.</p> <p>17 Q. So Cigna's reimbursement to the hospital</p> <p>18 would generally be greater than its reimbursement to a</p> <p>19 physician's office for administration of the same</p> <p>20 product?</p> <p>21 MR. ST. PHILLIP: I'm going to object.</p> <p>22 Q. Is that correct?</p>
<p style="text-align: right;">75</p> <p>1 MR. ST. PHILLIP: Objection.</p> <p>2 THE WITNESS: Could you repeat the</p> <p>3 question.</p> <p>4 (The court reporter read back.)</p> <p>5 A. The reimbursement to the providers is the</p> <p>6 result of the negotiations, and while as we cannot</p> <p>7 determine if that reimbursement will allow us -- will</p> <p>8 allow the provider to make a profit or not, it is in</p> <p>9 Cigna's interest that providers do stay in business,</p> <p>10 because they are the ones that are servicing our</p> <p>11 members.</p> <p>12 Q. Does Cigna have a preference for the site</p> <p>13 that a physician administered drug is administered?</p> <p>14 MR. ST. PHILLIP: I'm sorry, can you</p> <p>15 read that back.</p> <p>16 (The court reporter read back.)</p> <p>17 A. To my knowledge, no. The -- we want doctors</p> <p>18 following standard medical protocols, but I do not know</p> <p>19 of a specific statement of any sort related to that</p> <p>20 matter.</p> <p>21 Q. For example, if a particular drug could be</p> <p>22 administered in a physician's office but could also be</p>	<p style="text-align: right;">77</p> <p>1 MR. ST. PHILLIP: The court excluded</p> <p>2 deposition topic No. 18 which reads, whether</p> <p>3 and to what extent you provide different</p> <p>4 reimbursement rates for subject drugs when</p> <p>5 they are administered in providers' offices</p> <p>6 rather than in hospitals, including your</p> <p>7 clients' rationale for doing so or not doing</p> <p>8 so. The Magistrate Judge excluded that</p> <p>9 testimony, so I instruct the witness not to</p> <p>10 answer.</p> <p>11 MS. SCHOEN: Well, clearly we disagree</p> <p>12 and feel that this deposition topic falls</p> <p>13 under other areas.</p> <p>14 For purposes of moving forward today, we</p> <p>15 will move forward.</p> <p>16 Q. Do you have any knowledge that doctors have</p> <p>17 conspired with drug manufacturers to inflate drugs'</p> <p>18 average wholesale price?</p> <p>19 MR. ST. PHILLIP: Object insofar as it</p> <p>20 calls for a legal conclusion, but you can</p> <p>21 answer.</p> <p>22 A. I have no knowledge.</p>

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21 (Pages 78 to 81)

<p>1 Q. Do you have any knowledge of any activities 2 undertaken by any drug manufacturers to inflate the 3 average wholesale prices for their drugs? 4 MR. ST. PHILLIP: Same objection. 5 Go ahead. 6 A. I have no knowledge. 7 MS. SCHOEN: I think if I could, I'm 8 probably about to wrap up here. I have to 9 look over my notes. 10 Ed, are you going to have any questions 11 of this witness? 12 MR. NOTARGIACOMO: Yes, a few. Not too 13 long. 14 MS. SCHOEN: I have just a couple more 15 questions. 16 Q. How does Cigna determine whether it's 17 achieving a competitive reimbursement level when 18 negotiating with providers? 19 MR. ST. PHILLIP: Objection. 20 A. We try to find the most credible sources of 21 information that we can, and sometimes we'll get 22 information from the providers. We can also look at</p>	<p>78 1 information we would have had when we first made the 2 decision. 3 MR. ST. PHILLIP: It relates to the 4 bankruptcy filings of the physicians groups. 5 MS. SCHOEN: I have no further questions 6 at this time. 7 Ed? 8 9 CROSS EXAMINATION. 10 BY MR. NOTARGIACOMO: 11 Q. Ms. Herbold, I'll be very brief. If you 12 can't understand -- my name is Ed Notargiacomo. I'm 13 not sure if I introduced myself to you prior to today. 14 I represent the Plaintiff in this action, and I have a 15 few more questions. 16 This afternoon, I guess, and partially 17 this morning -- I'm losing track at this point -- you 18 testified about -- I think it's payment to physicians 19 for -- to physicians and physician groups for physician 20 administered drugs provided to or administered to Cigna 21 members; is that fair to say? 22 A. Could I ask that you repeat that question so</p>
<p>79 1 what we paid to other providers for the same or similar 2 types of services. 3 Q. So on occasion, Cigna uses external sources 4 to assess its reimbursement levels to providers, is 5 that correct? 6 MR. ST. PHILLIP: Objection. 7 A. Yes. The assessments that we're able to do 8 are -- that would really be external are not to 9 specific provider groups but rather to the competitive 10 position in the overall market. 11 Q. Does Cigna attempt to lower its negotiated 12 rates with physicians over time? 13 A. Cigna tries to get competitive rates with 14 physicians because we need to control the medical costs 15 for our members. Sometimes that means competitive -- 16 we give increases. Other times it means decreases. 17 Q. And does Cigna have a way of determining 18 whether any increases or decreases of the reimbursement 19 rate in an attempt to be competitive have gone too far 20 or gone not far enough in the case of an increase? 21 A. We don't have any specific way to assess that 22 beyond a retrospective look at the same type of</p>	<p>81 1 I make sure I understand it correctly. 2 MR. NOTARGIACOMO: I'm sorry, I couldn't 3 hear. 4 (The court reporter read back.) 5 Q. It really is a preparatory question. 6 You testified today about the payment by 7 Cigna to physicians for physician administered drugs, 8 is that correct? 9 A. Yes. 10 Q. And in that you talked about two distinct 11 time periods: One time period being pre-2002; is that 12 correct? 13 A. Could you repeat that. 14 Q. One of the time periods we talked about is 15 the pre-2002 time period? 16 A. My testimony today related primarily to the 17 period like 2002 and later. I provided a little 18 testimony related to prior to 2002 based on my 19 conversations with people that have knowledge of that 20 time. 21 Q. Still sticking with the pre-2002 time period, 22 based on your conversation with people in Cigna who</p>

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22 (Pages 82 to 85)

<p style="text-align: right;">82</p> <p>1 have knowledge of that period, is it your testimony</p> <p>2 that Cigna reimburses the physician at a rate, a</p> <p>3 negotiated rate; but a rate that was a percentage off</p> <p>4 of -- expressed as a percentage off of average</p> <p>5 wholesale price or AWP, is that correct?</p> <p>6 MS. SCHOEN: Objection to form.</p> <p>7 MR. ST. PHILLIP: If you could do that</p> <p>8 one more time, we just increased in volume so</p> <p>9 we'll be able to do it.</p> <p>10 Q. Sticking with the period from 2002 earlier,</p> <p>11 I'm basing your conversations with people at Cigna, was</p> <p>12 it your testimony today that Cigna reimburses</p> <p>13 physicians or reimbursed physicians at a price that was</p> <p>14 a discount off of average wholesale price?</p> <p>15 MS. SCHOEN: Objection to form.</p> <p>16 Q. Is that correct?</p> <p>17 A. Prior to 2002, Cigna reimbursed physicians at</p> <p>18 the negotiated rates. Those negotiated rates were</p> <p>19 commonly expressed as percent of AWP. They may have</p> <p>20 also been expressed as a percent of billed charges, but</p> <p>21 those are the only two approaches that I'm aware of.</p> <p>22 Q. And then for the period from 2002 on, you</p>	<p style="text-align: right;">84</p> <p>1 part of the formula that is also based on average</p> <p>2 wholesale price, is that correct?</p> <p>3 A. That is correct.</p> <p>4 Q. Would you agree with me that Cigna's goal is</p> <p>5 to get the best -- when negotiating with physicians</p> <p>6 about the reimbursement for physician administered</p> <p>7 drugs, would you agree that Cigna's goal is to get the</p> <p>8 best deal it can for itself while providing adequate</p> <p>9 reimbursement to physicians for the drugs it</p> <p>10 administers to its members?</p> <p>11 A. Yes.</p> <p>12 Q. And is it fair to say that Cigna expects that</p> <p>13 the doctors in its network to make a living primarily</p> <p>14 providing treatment to patients and not from large</p> <p>15 markups on those physician administered drugs?</p> <p>16 MS. SCHOEN: Objection to form.</p> <p>17 A. Could you please repeat the question.</p> <p>18 Q. Sure.</p> <p>19 Is it fair to say that Cigna expects</p> <p>20 that doctors in its networks are -- make their living</p> <p>21 primarily providing treatment to patients and the</p> <p>22 payment from providing treatment to patients and not</p>
<p style="text-align: right;">83</p> <p>1 said that approximately 50 percent of reimbursement is</p> <p>2 done at or under that same methodology as a negotiated</p> <p>3 price off of the average wholesale price or as a</p> <p>4 percentage of bill charged; is that correct?</p> <p>5 A. That is correct.</p> <p>6 Q. And the other 50 percent is based on Cigna's</p> <p>7 national standard pricing list, is that correct?</p> <p>8 A. Yes, that is correct.</p> <p>9 Q. And even the prices on Cigna's national</p> <p>10 standard pricing list are expressed as a percentage off</p> <p>11 of average wholesale price, is that correct?</p> <p>12 A. Yes, some of them are. Not all of them are.</p> <p>13 Q. Some of them are.</p> <p>14 The ones that aren't, are you referring</p> <p>15 specifically to the 13 -- the drugs that fall under the</p> <p>16 13 codes that are based --</p> <p>17 A. Yes.</p> <p>18 Q. -- on something different?</p> <p>19 A. Yes.</p> <p>20 Q. And those exceptions, those 13 codes, the</p> <p>21 reimbursement methodology for those drugs is based on</p> <p>22 acquisition costs, but isn't it true that it also has a</p>	<p style="text-align: right;">85</p> <p>1 from large markups on prescription drugs that it</p> <p>2 administers?</p> <p>3 MS. SCHOEN: Objection to form.</p> <p>4 A. With respect to the reimbursement of</p> <p>5 practitioners for their services, we expect that the</p> <p>6 physician is negotiating with us and another carrier so</p> <p>7 that they can maintain sufficient profit margin to</p> <p>8 operate their business and stay in business. We don't</p> <p>9 have a specific expectation about exactly what their</p> <p>10 billed charges might be for a particular service</p> <p>11 because it's a difference between that billed charge</p> <p>12 and the reimbursement amount that I would call and</p> <p>13 refer to as a markup.</p> <p>14 Q. When you use the term billed charge, what are</p> <p>15 you referring to?</p> <p>16 A. What I'm referring to there is the fee amount</p> <p>17 that the physician would submit on the claim in order</p> <p>18 for the claim to get paid. It's -- another way to say</p> <p>19 it is it is the amount that the physician would charge</p> <p>20 for an indemnity member.</p> <p>21 Q. Let's turn back to the 13 codes that we</p> <p>22 talked about a few minutes ago.</p>

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23 (Pages 86 to 89)

<p>1 I believe you testified that one -- and</p> <p>2 correct me if I'm wrong -- that the reason that Cigna</p> <p>3 singled out these 13 codes for different treatment was</p> <p>4 the fact that there became available on the market</p> <p>5 generic forms of those drugs that were available at a</p> <p>6 cheaper price, is that accurate?</p> <p>7 A: Yes, and let me clarify. Our change that we</p> <p>8 made was in reaction to the result of competitive</p> <p>9 market forces. Generic drugs were introduced that</p> <p>10 drove down the acquisition cost, the cost of the</p> <p>11 product in the marketplace.</p> <p>12 Q: And the change -- were you finished?</p> <p>13 A: Yes -- I'm finished, yes.</p> <p>14 Q: And the change in the reimbursement for those</p> <p>15 codes that Cigna instituted, was that an attempt to</p> <p>16 bring physician reimbursements for those codes in line</p> <p>17 with the lower price available in the marketplace for</p> <p>18 those drugs?</p> <p>19 A: Yes.</p> <p>20 Q: So if Cigna had information that other drugs</p> <p>21 other than that 13 were available for a price that was</p> <p>22 significantly less than the reimbursement that Cigna</p>	<p>86</p> <p>1 whether Cigna understands what physicians paid for</p> <p>2 physician administered drugs, you just testified that</p> <p>3 Cigna didn't have an understanding of that.</p> <p>4 Is that generally your testimony?</p> <p>5 A: We don't have specific knowledge about it.</p> <p>6 The knowledge that we have is just based on what --</p> <p>7 it's really based on we set a fee amount, and the</p> <p>8 providers come back and complain about it or they</p> <p>9 don't. So it's not that we understand their specific</p> <p>10 acquisition costs, but if our reimbursement is too low,</p> <p>11 we hear about it.</p> <p>12 Q: I think you testified that one of the</p> <p>13 exceptions is some -- with respect to some</p> <p>14 manufacturers of immunization products.</p> <p>15 Do you remember testifying about that?</p> <p>16 A: I'm sorry, can you please repeat that</p> <p>17 question?</p> <p>18 Q: Sure.</p> <p>19 I think that you testified with respect</p> <p>20 to having had some contact with some manufacturers of</p> <p>21 immunization products?</p> <p>22 A: Yes.</p>
<p>87</p> <p>1 currently provides in its national standard price list,</p> <p>2 would Cigna take steps to try to bring the</p> <p>3 reimbursement rate that it provides down to the level</p> <p>4 that's available -- the level of reimbursement that's</p> <p>5 available to doctors who purchase in the marketplace?</p> <p>6 MS. SCHOEN: Objection to form.</p> <p>7 A: Cigna is trying to make sure that we maintain</p> <p>8 -- well, that we have competitive medical costs that we</p> <p>9 are able to sell our products and have members, and</p> <p>10 Cigna is -- also has an interest, as I've stated, in</p> <p>11 making sure that the providers can stay in business.</p> <p>12 And in terms of applying that to the</p> <p>13 reimbursement for specific drugs, we made those changes</p> <p>14 reflecting the changes that were going on in the</p> <p>15 marketplace, and also what physicians were willing to</p> <p>16 accept for reimbursement.</p> <p>17 I mean, another way of thinking about</p> <p>18 that is that we ranked the changes that we're aware of</p> <p>19 in terms of market price changes, but it also -- we</p> <p>20 have to factor in what is the reimbursement amount that</p> <p>21 physicians are willing to accept.</p> <p>22 Q: You testified that -- when you were asked</p>	<p>88</p> <p>1 Q: And in that way learning what the physician</p> <p>2 acquisition price for immunization products -- at least</p> <p>3 some products are; is that accurate?</p> <p>4 A: That is accurate. My prior comment was</p> <p>5 related to injectables. I'm sorry, I didn't clarify</p> <p>6 that.</p> <p>7 Q: That's okay.</p> <p>8 As with respect to the immunization</p> <p>9 products and the information that Cigna obtained with</p> <p>10 respect to those conversations, did that information</p> <p>11 then -- was that used by Cigna in determining what</p> <p>12 reimbursement it would provide to physicians for those</p> <p>13 immunization products?</p> <p>14 A: That's a very interesting question. As I</p> <p>15 mentioned, it is in the recent past, and to be more</p> <p>16 specific, the last month and a half, that we have</p> <p>17 gotten that information, and we have yet to make a</p> <p>18 determination about exactly how we're going to set our</p> <p>19 reimbursement on immunizations going forward.</p> <p>20 MR. NOTARGIACOMO: I have no other</p> <p>21 questions.</p> <p>22 MR. ST. PHILLIP: I have none.</p>

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Bloomfield, CT

24 (Pages 90 to 92)

<p>1 MR. WADE: None for me.</p> <p>2 MS. SCHOEN: I have just a couple more</p> <p>3 questions.</p> <p>4</p> <p>5 REDIRECT EXAMINATION</p> <p>6 BY MS. SCHOEN:</p> <p>7 Q. The time period prior to 2002, you testified</p> <p>8 as to the reimbursement methodologies generally</p> <p>9 employed during that time period. One was a</p> <p>10 methodology based on the average wholesale price, and</p> <p>11 the other was billed charges.</p> <p>12 My question goes to the reimbursement</p> <p>13 based on average wholesale price.</p> <p>14 Can you tell me whether there was</p> <p>15 variability in the reimbursement percentage above or</p> <p>16 below AWP during the time prior to 2002?</p> <p>17 MR. ST. PHILLIP: Objection. Asked and</p> <p>18 answered.</p> <p>19 Go ahead.</p> <p>20 A. I have no specific knowledge. However, I</p> <p>21 would have a hard time believing that there wasn't some</p> <p>22 variation as a result of provider negotiations.</p>	<p>90</p> <p>1 CERTIFICATE</p> <p>2 I, DIANA M. NOEL, a Registered Professional</p> <p>3 Reporter, Certified Realtime Reporter, Licensed</p> <p>4 Shorthand Reporter, and Notary Public duly commissioned</p> <p>5 and qualified in and for the State of Connecticut, do</p> <p>6 hereby certify that there came before me JILL S.</p> <p>7 HERBOLD, who was by me duly sworn and thereupon</p> <p>8 testified as appears in the foregoing deposition; that</p> <p>9 said deposition was taken by me stenographically in the</p> <p>10 presence of counsel and reduced to writing under my</p> <p>11 direction; that this deposition is a true record of the</p> <p>12 testimony given by the witness.</p> <p>13</p> <p>14 I further certify that I am neither attorney nor</p> <p>15 counsel for, nor related to, nor employed by any of the</p> <p>16 parties to the action in which this deposition is</p> <p>17 taken, and further that I am not a relative or employee</p> <p>18 of any attorney or counsel employed by the parties</p> <p>19 hereto, or financially interested in the action.</p> <p>20</p> <p>21 IN WITNESS THEREOF, I have hereunto set my hand</p> <p>22 this 19th day of January, 2005.</p> <p>23</p> <p>24</p> <p>25</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47</p> <p>48</p> <p>49</p> <p>50</p> <p>51</p> <p>52</p> <p>53</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p> <p>59</p> <p>60</p> <p>61</p> <p>62</p> <p>63</p> <p>64</p> <p>65</p> <p>66</p> <p>67</p> <p>68</p> <p>69</p> <p>70</p> <p>71</p> <p>72</p> <p>73</p> <p>74</p> <p>75</p> <p>76</p> <p>77</p> <p>78</p> <p>79</p> <p>80</p> <p>81</p> <p>82</p> <p>83</p> <p>84</p> <p>85</p> <p>86</p> <p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>91</p> <p>92</p> <p>93</p> <p>94</p> <p>95</p> <p>96</p> <p>97</p> <p>98</p> <p>99</p> <p>100</p> <p>101</p> <p>102</p> <p>103</p> <p>104</p> <p>105</p> <p>106</p> <p>107</p> <p>108</p> 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<p>91</p> <p>1 MS. SCHOEN: No further questions.</p> <p>2 MR. ST. PHILLIP: We're done.</p> <p>3 (The deposition adjourned at 5:00 PM.)</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p>	<p>92</p>





Jill S. Herbold

January 14, 2005

Bloomfield, CT

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